December 14, 2023 | Volume 28 ■ Issue 25

ISMP An ECRI Affiliate

Acute Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

ISMP 26TH ANNUAL CHEERS AWARDS

HITTING THE SAFETY HIGH NOTES

This month, ISMP celebrated the 26th annual **CHEERS AWARDS**, which recognize individuals, organizations, and groups that have demonstrated extraordinary commitment to advancing the science, study, and practice of medication safety. This year's winners were honored at an awards ceremony held on December 5, 2023, at the House of Blues in Anaheim, CA. Please join us in congratulating this impressive group of medication safety virtuosos, who have shown outstanding dedication to reducing adverse events and infection risks and supporting second victims of medication errors.

CHEERS AWARDS winners

Boston Medical Center was recognized for its implementation of barcode medication administration (BCMA) and positive patient identification (PPID) prior to administering any medication or vaccine in ambulatory care settings. One of the ***2023-2024 ISMP Targeted Medication Safety Best Practices for Hospitals*** calls for expanding BCMA beyond inpatient areas. Boston Medical Center began to incorporate the technology into their general and family medicine clinics in early 2023, achieving a scanning compliance rate of 98%. However, the team realized there were still gaps in their process—ambulatory clinics. Here, patients were not receiving a patient identification band, so staff were still verbally verifying patient name and date of birth prior to medication administration. Both BCMA and PPID were implemented in the pediatric clinics to address this gap, and scanning compliance has been successful at 97%. This process has averted numerous close calls, particularly in the identification of the correct patient when siblings were in the same exam room and required immunizations. In addition, through a direct computer interface with the Massachusetts Immunization Information System, vaccine documentation is automatically being sent to the state registry, improving the accuracy of patients' vaccine records. Boston Medical Center's end goal is successful deployment of BCMA and PPID in all 45 of its ambulatory clinics that administer medication and vaccines.

Corewell Health in Grand Rapids, MI, was honored for eliminating inadvertent infection exposure of multi-use insulin pens in their organization by implementing the use of a patient-specific barcode on the pen to help prevent using it for multiple patients. After a gap analysis, a multidisciplinary team led by a physician assistant, a pharmacist, and an information technology analyst identified ways to prevent patient-to-patient exposures involving insulin pens. The team used a layered approach of low-, mid-, and high-level strategies over a period of three years. They built an additional layer of safety by developing an automated process in which patient-specific barcode labels are printed and applied to multi-use medications on the nursing unit. Printers were installed in each medication room and all formulary insulin pens were moved to the automated dispensing cabinet (ADC). Once insulin pens are removed from the ADC, a patient-specific label is applied before it leaves the room. Before administration, nurses scan the patient's wristband, patient-specific barcode on the pen, and the manufacturer's barcode. After all three scans are complete, the system allows them to proceed. Since implementation, Corewell Health has had zero patient exposures. They have shared their process at the state, local, and national levels and with Epic, who intends to include it in their software update in 2024.

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SAFETY briefs

Confusion over sterility of povidone-iodine solution. A hospital reported that labeling on the overwrap of **APLICARE** (povidone-iodine solution), an antiseptic product made by Medline, seems to indicate that the solution is sterile (**Figure 1**). However, while the foil package itself, inside the overwrap, is sterile, its contents are NOT (**Figure 2**, page 2). Placing a non-sterile solution in a package labeled "sterile" will cause confusion among providers who may believe they are choosing a sterile solution when they are not.

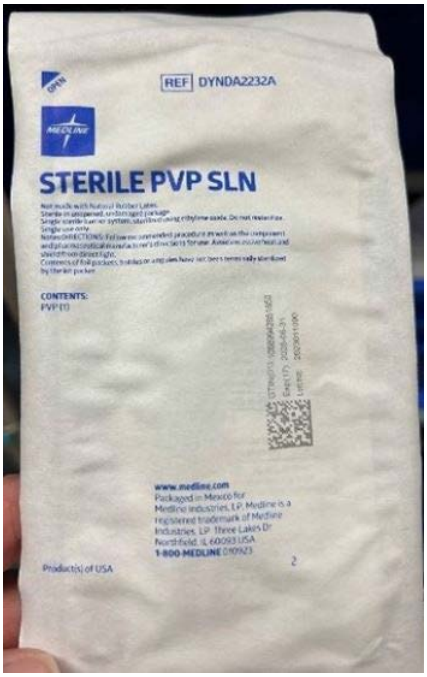

Figure 1. Overwrap on Aplicare (povidone-iodine solution) by Medline indicates that the package is sterile.

We reached out to the manufacturer to notify them of the concern. They advised us that they have updated the back of the peel pouch description on the overwrap to state "NON-STERILE PVP SOLUTION, STERILIZED PACKAGING" to lessen confusion. Educate practitioners that Aplicare (povidone-iodine solution) is not sterile and should not be used when a sterile solution is required.

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LIFETIME ACHIEVEMENT AWARD winner

One of the many highlights of the evening was the presentation of the 2023 ISMP **LIFETIME ACHIEVEMENT AWARD**, which is given in memory of ISMP's late Trustee David Vogel, PharmD. The award honors individuals who have made ongoing contributions to medication safety throughout their career. This year's honoree, ***Susan Donnell Scott, PhD, RN, CPPS, FAAN***, has dedicated her career to developing a strong peer support for clinicians and second victims of medication errors.

Dr. Scott's groundbreaking research has helped define the second victim phenomenon, and increased understanding of the unique needs of healthcare team members during the aftermath of unexpected clinical events. She designed and deployed a first-of-its-kind peer support network, the forYOU Team, at the University of Missouri Health Care System in Columbia, MO. This evidence-based and holistic approach to provision of institutional support, promotes the psychological safety of staff during the period of extreme stress following emotionally challenging clinical events, and has become an international model for healthcare organizations seeking to create their own support structure.

In addition to leading the forYOU Team, Dr. Scott currently practices as a nurse scientist at the University of Missouri Health Care System and is an adjunct associate professor at the Sinclair School of Nursing. She has partnered with other organizations, including the Agency for Healthcare Research and Quality, the American Hospital Association, The Joint Commission, the Institute for Healthcare Improvement, and Medically Induced Trauma Support Services to ensure that comprehensive second victim support interventions are accessible to healthcare institutions and practitioners around the world.

In her acceptance remarks, Dr. Scott emphasized that offering accessible and effective support for second victims should not be seen as a choice for staff, but an expected and consistent response. She called on organizations to address second victim experiences spanning the whole spectrum of severity, and to proactively nurture a supportive environment that considers the overall well-being of healthcare professionals. She noted that each individual possesses the power to contribute to this transformative vision, irrespective of position or title. Dr. Scott expressed optimism about the future that the entire healthcare community can collectively help shape, creating workplaces that cultivate innovation, inclusivity, kindness, and positive change.

Special Guest Speaker

This year's **CHEERS AWARDS** dinner also featured a special guest who has herself been a second victim—***RaDonda Vaught***, a former nurse criminally prosecuted for a fatal medication error. ISMP and many other healthcare organizations spoke out in support of RaDonda and against the criminalization of medication errors during her highly publicized trial and sentencing. In an onstage conversation with ISMP President Rita Jew, RaDonda shared her compelling story regarding the human side of medication-related mistakes and the impact of the error on everyone involved. She stressed how much ISMP and ECRI's public statement about her case meant to her, and ways she has found some closure. She touched on the systems that, if they had been in place, could have prevented the error and why she continues to feel that speaking up about issues, including medication error reporting, is essential for organizational learning.

Thanks, and Looking Forward

We would like to express our immense gratitude to all of the organizations and individuals who attended and/or supported this year's **CHEERS AWARDS**. For a list of contributors and winners, please visit: www.ismp.org/node/83407, and for ways you can join us in creating a brighter future for medication safety, please visit: www.ismp.org/support.

ISMP wishes everyone happy holidays, and we look forward to continuing to work together on preventing medication errors and keeping patients safe in 2024.

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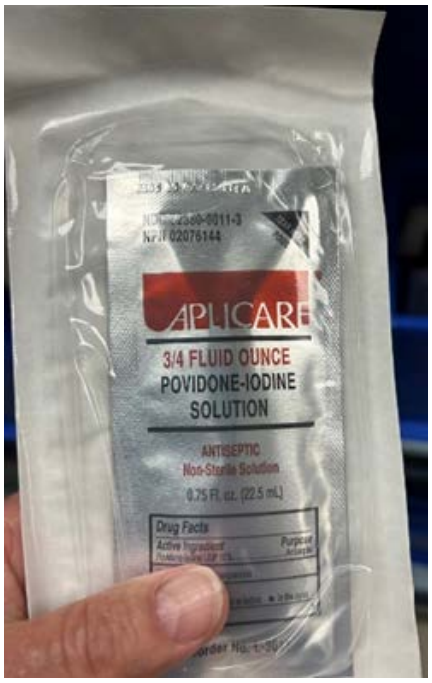

Figure 2. The content inside the Aplicare foil package is a non-sterile solution.

12-month prescriptions are not the answer to overwhelmed pharmacy staff. There has been quite a bit of media coverage lately regarding unsafe working conditions in retail pharmacies, and it is coming from the nation's community pharmacists themselves—especially those who work in large chain pharmacies. In fact, during September and October, thousands of pharmacists protested working conditions with walkouts they called, "Pharmageddon."

These pharmacists say that operational burdens coupled with inadequate staffing are risking their ability to safely dispense medications. Pressures deepened due to the coronavirus 2019 disease (COVID-19) pandemic when pharmacies expanded clinical services, such as offering wide-scale vaccinations. Pharmacy staff participating in these walkouts say they are doing so in the name of medication safety, to emphasize that they cannot continue to do more without additional resources. We agree!

Recently, we came across an article, *Filling 12-month prescriptions is one practical way to help the pharmacist crisis* (www.ismp.org/ext/1283), that suggests moving

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The next newsletter will be published on **January 11, 2024**. ***See you next year!***

Unintentional oral ingestion of boric acid vaginal suppositories

A physician told a woman with a vaginal infection to use boric acid suppositories to help relieve symptoms of vaginitis, such as a bad odor. Boric acid (a pesticide that is harmful when taken orally) suppositories are sold over-the-counter (OTC). However, they come as a gelatin capsule that contains powder and look similar to encapsulated medications. In fact, people who have previously had an infection may have been prescribed a medication in capsule form, such as an oral antibiotic, making them believe the boric acid capsule should be taken orally. Patients may not be familiar with capsules used as suppositories. In addition, patient health literacy in the United States is poor (www.ismp.org/node/110339), so it is not surprising that these instructions were misunderstood.

In the report we received, the patient swallowed one of the suppositories. Later, when she read the container label more carefully, she realized the capsules were meant for vaginal insertion. There was also a warning on the container that said, "For vaginal use only, not for oral consumption. If swallowed, get medical help and call poison control right away." The woman decided to go to an emergency room. According to Poison Control (www.ismp.org/ext/1253), the small amount of boric acid in a single capsule would not be expected to cause harm. However, ingesting large amounts of boric acid may result in gastrointestinal distress, kidney problems, or death. Fortunately, the patient did not suffer any serious problems. A search of the internet revealed numerous other cases of women swallowing boric acid suppositories unintentionally.

Women having vaginal symptoms, such as itching, discharge, or a new odor, should see a healthcare professional who can diagnose the issue and recommend proper treatment. Although boric acid is available OTC, a healthcare professional might recommend a different treatment specific to the diagnosis.

Boric acid suppositories are available from multiple companies and labeling is inconsistent. Although these products are labeled vaginal suppositories, they are often packaged in plastic bottles as loose capsules that resemble oral medications or dietary supplement products. Some boric acid suppository container labels are visually attractive and may distract the patient from reading important information (**Figure 1**).

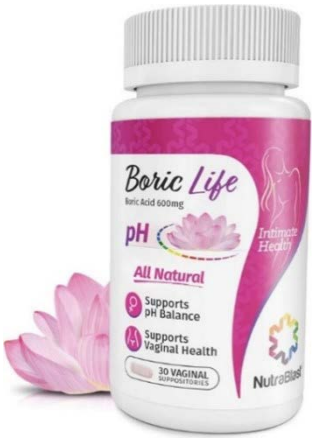

Figure 1. Consumers may overlook the description of the contents (i.e., vaginal suppositories) that appears at the bottom of the label on this OTC product.

Given that boric acid suppositories are easily confused as oral capsules, we are asking the US Food and Drug Administration (FDA) and product manufacturers to investigate ways that this error can be prevented. For example, consider reformulating products so they are shaped as suppositories. Most suppositories are waxy and small, with a round or cone shape, and vaginal suppositories are usually not gelatin capsules filled with powder. These products should also be sold in unit-of-use blister packs, with the carton holding enough for use over a typical course of treatment, which is usually 7 to 14 days. Vaginal products should also include an applicator with instructions and a link to a professional video that explains what vaginal suppositories are and how to properly use them. Additionally, the cartons and individual blisters need to call out the name of the product, "boric acid," and warn, "For vaginal insertion only" more prominently.

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to dispensing prescriptions for chronic medications annually instead of monthly, or every 90 days, would alleviate overworked pharmacists. Providing patients with twelve months of medication in a single prescription pick-up may be a time-saving solution, but we are concerned that it would introduce medication safety concerns (i.e., counting errors due to large quantity, labeling multiple packages).

While some exclusions (e.g., new prescriptions, titratable doses, controlled substances) were suggested, this is definitely NOT the best approach to solve the problem. Even medications that are deemed "chronic," may be changed at some point (e.g., switched to a different medication or formulation, dose increased or decreased based on clinical findings, changes in the insurance formulary). With a year's supply at home, patients may take a medication that is no longer needed, or take a discontinued dose along with a newly prescribed dose for months, until harm occurs or the error is otherwise identified. During a time of frequent drug shortages, yearly dispensing would also cause more medications to be wasted when inevitable changes occur. In addition, this added pressure on the supply chain (e.g., dispensing 365 tablets instead of 30 tablets), could result in worsening of drug shortages for some products, not to mention that most pharmacies may not have the space to safely store the increased volume of inventory. Also, if a patient is on multiple chronic medications, they would need to be able to store them safely and securely at home under the right conditions, and take steps to avoid an intentional or accidental overdose. The potential risk for using expired medications when storing large supplies at home also increases. So, for safety's sake, relying on annual prescription fills as a quick fix for overwhelmed and under resourced pharmacies is clearly NOT the answer.

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Happy Holidays from the staff, Board of Directors, and Advisory Board at the Institute for Safe Medication Practices (ISMP). We wish you joy, health, and happiness this holiday season!

Special Recognition... Our 2023 Acute Care Clinical Advisory Board

Production of this peer-reviewed newsletter would not be possible without the assistance of a reliable and talented clinical advisory board. As 2023 nears an end, we want to thank each of the following members of the advisory board for their dedication to making this newsletter a valuable medication safety resource for clinicians.

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